



**PATIENT CONSENT FORM
FOR THE TREATMENT OF PIGMENTED LESIONS**

I hereby authorize Dr. _____ or any delegated associates, to perform pigmented lesion treatment with a light-based device on me. I understand that this procedure treats pigmented lesions, age spots, and sun spots by targeting melanin with a bright pulsed light. I understand I may not experience complete clearance and that it may take multiple treatments. Some conditions may not respond at all and in rare cases may become worse.

I am aware of the following possible experiences/risks:

- DISCOMFORT – Some discomfort may be experienced during treatment.
- REDNESS/SWELLING/BRUISING –Short term redness (erythema) is common and swelling (edema) of the treated area may occur. Additionally, there may be some bruising.
- PIGMENT CHANGES (Skin Color) – During the healing process, there is a slight possibility that the treated area can become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- WOUNDS – Treatment can result in burning, blistering or bleeding of the treated areas. If any of these occur, please call our office.
- INFECTION - Infection is a rare possibility whenever the skin surface is disrupted, though proper wound care should prevent this. If signs of infection develop, such as pain, heat or surrounding redness, please call our office __ (Phone number)_____.
- SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin’s surface is disrupted. To minimize the chance of scarring, it is IMPORTANT that you follow all post-treatment instructions carefully.
- EYE EXPOSURE – Protective eyewear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from injury.

The following points have been discussed with me:

- The potential benefits of the proposed procedure
- The possible alternative procedures such as liquid nitrogen, topicals, or cutting them off
- The probability of success
- The reasonably anticipated consequences if the procedure is not performed
- The most likely possible complications/risks involved with the proposed procedure and subsequent healing period
- Post treatment instructions

For women of childbearing age. By signing below I indicate that I am not pregnant. Futhermore, I agree to keep Dr. _____ and staff informed should I become pregnant in the course of treatment.

Photographic documentation will be taken. I hereby do ___do not___ authorize the use of my photographs for teaching purposes.

ACKNOWLEDGMENT:

BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR LIGHT BASED TREATMENT OF MY PIGMENTED LESIONS, AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

Signature-Patient or Guardian

Print Name/Relationship

Date

Signature-Witness

Print Name

Date